New Patient Information

Name: ______________________________ DOB: ______________

Address: ____

Phone: ________________ Reason for visit: ________________

- **Past Medical History/Family History:** (Specify and describe any past medical conditions you have/had or any conditions your mother, father, brother, sister, child, maternal/paternal grandparents, etc.)

Condition	Self or Family Member and Describe	Condition	Self or Family Member and Describe
Headache		Ulcers	
Stroke		Heart burn/Reflux	
Seizures		Wounds	
Macular Degeneration		Cancer	
Glaucoma		Urine Infections	
Hearing loss		Incontinence	
Asthma		Kidney Stones	
COPD		Hepatitis	
Pneumonia		HIV/AIDS	
High Blood Pressure		Depression	
Pulmonary blood clot		Bipolar	
Leg blood clots		Anxiety	
Valve Disorder		Fibromyalgia	
Angina (chest pain)		Arthritis	
Heart Disease		Gout	
Heart Attacks		Osteoporosis	
Congestive Heart Failure		Prostate issues	
Atrial Fibrillation		Breast disease	
High cholesterol		Erectile dysfunction	
Thyroid Disease		Diabetes Type 1 or 2	

- **Medications:** (include all medications including daily or on an as needed basis as well as herbs)

Name of Medication	Dosage	Reason Taken

- **Medication Allergies:**

Name of Medication	Type of Reaction

• Surgical History: (List all surgeries you have had in the past)

Type of Surgery	Year
(Example: Gall Bladder Removed)	*(2010)*
___________________________	____________________
___________________________	____________________
___________________________	____________________
___________________________	____________________

• Social History:

_____ Married
_____ Single
_____ Widowed
_____ Divorced   With whom do you live? ____________________________________

Have you ever smoked? _____ No _____ Yes
_____________________ When did you quit?
_____________________ How many years did you smoke?

Do you currently smoke? _____ No _____ Yes
_____________________ Type (cigarettes, pipe, cigars)
_____________________ Amount per day
_____________________ Number of years smoking

Do you drink alcohol? _____ No _____ Yes
_____________________ Type: (Beer, Wine, Liquor)
_____________________ Amount: (one, several, many)
_____________________ Social occasions only
_____________________ Once or twice a month
_____________________ Once or twice a week
_____________________ Daily

Do you use illegal drugs? _____ No _____ Yes
_____________________ Type: (Marijuana, Cocaine)
_____________________ Social occasions only
_____________________ Once or twice a month
_____________________ Once or twice a week
_____________________ Daily

Do you exercise routinely? ______No ______Yes
_____________________ Type

• Who was your previous Primary Care Provider: ____________________________________

• Specialists (Please list all specialists you see)

Name of Specialist	Type of Specialty
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________
___________________________	___________________________

____________________________________ ______________________
Signature Date